Fort Frances Tribal Health Area Health Services Inc.
Behaviour Health Services
P.O. Box 608, Fort Frances, Ontario, P9A3M9

Mino Ayaa Ta Win

“Helping Ourselves Heal”

Intake Form & Referral Package

Pre-Treatment Program

Outpatient Program

After-Care Program

Counselling Services

INTAKE FORM

Please indicate what program you are applying for

Pre-Treatment Program ___

Outpatient ___

After-Care Program ___

Counselling ___

File No:_____

New:_____

Re-open:_____

REFERRAL DATE:_____

Name:	Anishinaabe Name:
Spiritual Advisor, Elder:	Clan:
Community:	On Reserve:_____ Off Reserve:_____ Status Card Number:
Please describe your belief system:	
Street/Mailing Address:	City and Province:
Phone Number:	Email:
D.O.B.	AGE:
Sex: Male_____ Female_____	
Referred By:	Other Contact (s):
Reason for Referral:	
Suicide Risk: High_____ Med_____ Low_____ NA_____	
Other Notations:	

Referral Taken By:_____ Assigned To:_____

Supervisor Signature:_____

PLEASE INDICATE

☐ First nation ☐ Inuit ☐ Metis ☐ Caucasian ☐ Other
Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Common-law ☐ Widowed ☐ Married Name of Spouse/Partner: _____

Medical History

Family Doctor Name:	Telephone:	
Address:		
Please list any and all medications below:		
Name	Dose started	Prescribed by
Reason Prescribed	Dose current	When it started
Name	Dose started	Prescribed by
Reason Prescribed	Dose current	When it started
Name	Dose started	Prescribed by
Reason Prescribed	Dose current	When it started
Name	Dose started	Prescribed by
Reason Prescribed	Dose current	When it started
Do you have any allergies? ☐ Yes ☐ No	If yes, please name:	
Is Epi-Pen required for the above allergies?		

Do you have any of the following? (Please check all that apply)
☐ Ear/Hearing problems ☐ Arthritis ☐ Tuberculosis ☐ Hernia ☐ Convulsions/seizures ☐ Asthma ☐ Eye problems ☐ Head Injury ☐ Bowel problems ☐ Stomach problems ☐ Blood Pressure ☐ Cancer ☐ Pregnancy ☐ Heart Disease
Are there any major health concerns that you have that are not listed here? (Please List): _____ _____

EDUCATION

Highest Grade Completed	Name of last school attended
Have you had any learning difficulties in school?	

Employment Status

☐ Employed (Full-time, Part-time, Seasonal, Job Training) ☐ Unemployed ☐ Retired

Income Source

☐ Employment ☐ Employment Insurance ☐ Ontario Works ☐ Pension ☐ No Income

Preferred Language

☐ Ojibwe ☐ Oji-Cree ☐ Cree ☐ English ☐ Other _____

PERSON IN CASE OF AN EMERGANCY

Name:_____	
Phone number(MANDITORY):	Relationship to applicant:

Legal Status and History

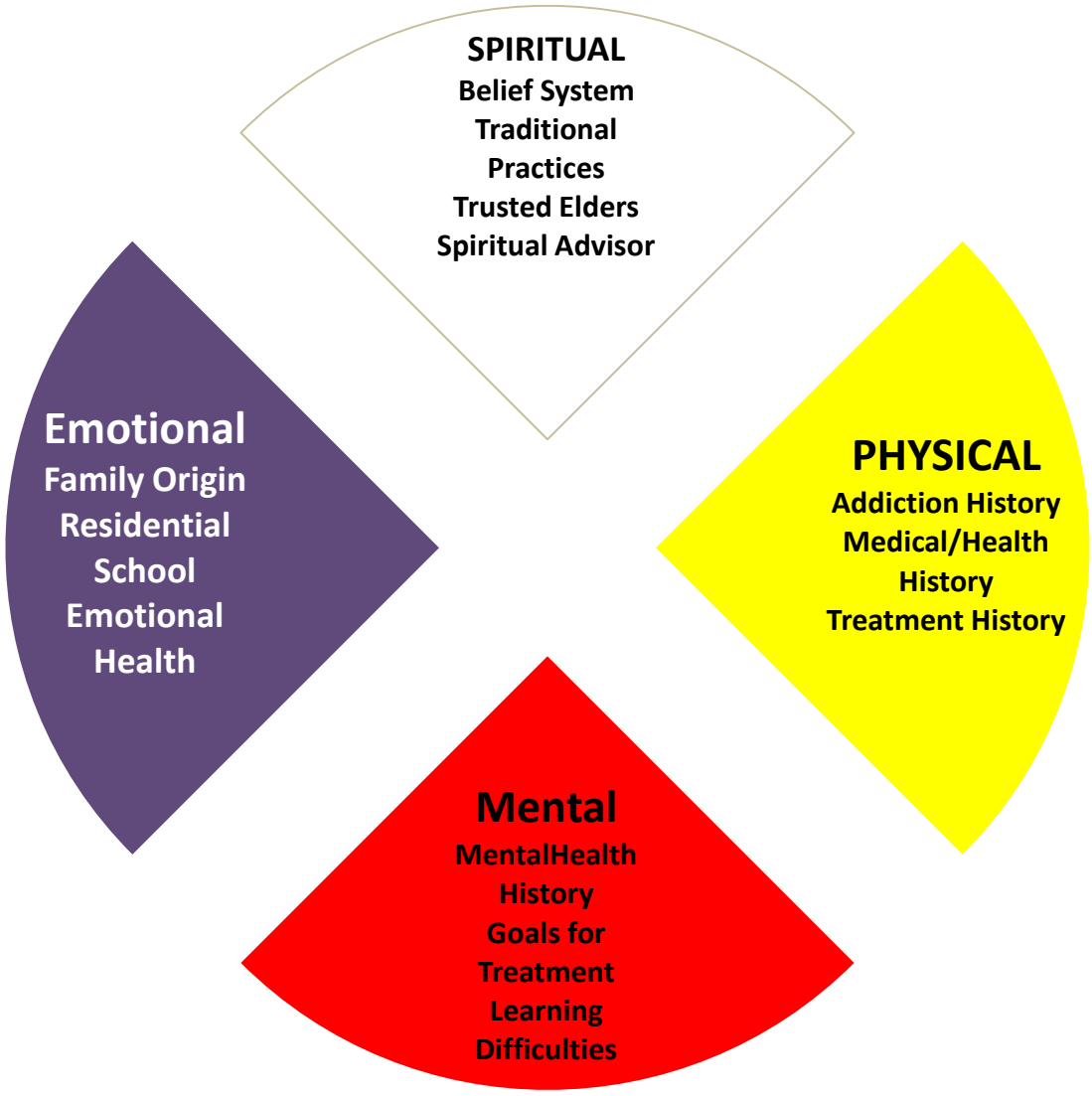
Current/Pending Charges ☐ Yes ☐ No		
List Charge(s):		
In Jail ☐ Yes ☐ No	Release Date	
On Probation ☐ Yes ☐ No	Start Date	End Date
Conditions:		
On Parole ☐ Yes ☐ No	Start Date:	End Date:
Conditions		
Do you have to attend criminal court?	When?	For What?
Probation /Parole Officer	Telephone Number	
Address		

Please indicate if you had any of the past offences listed below: (Check all that apply)			
☐ Arson	☐ Forgery	☐ Probation violation	☐ Willful damage/mischief
☐ Assault	☐ Impaired driving	☐ Robbery	☐ Criminal negligence causing death
☐ Break & Enter	☐ Manslaughter	☐ Sexual assault	
☐ Burglary	☐ Murder	☐ Theft	☐ Possession stolen property
☐ Drug Charges	☐ Parole violation	☐ Weapon offenses	

REFERRAL SOURCE INFORTMATION

Name of Referring Person	Position
Agency Name and Address	
Phone Number	Facsimile Number
What is the nature of your relationship with the client: (i.e. counsellor, advocate, family, doctor, ect?)	
How long have you known the client?	
Reason for involvement with referring person/agency:	
Give a brief description of the client's issues as you see them:	
What is your assessment of the client's level of motivation at this time?	
To your knowledge, has the client ever experienced psychiatric or psychological problems? If so, please explain)	
Please list the program and/or services available in your community for aftercare or follow up for this client.	

Medicine Wheel
What will be covered during treatment



PHYSICAL ASPECT OF SELF-ADDICTIONS HISTORY

THIS SECTION: IS TO BE COMPLETED BY THE CLIENT

Primary Substance	Approximate Date of Last Time Used	Age of First Use	Age Regular Use Began
1.			
2.			
3.			

Substances used in the last 12 months: (please check all that apply)

☐ Alcohol	☐ Crack	☐ Methadone
☐ Amphetamines, i.e. Ritalin	☐ Glue/inhalant	☐ Oxycontin
☐ Barbiturates, i.e. Phenobarbital	☐ Hallucinogens, i.e. Ecstasy	☐ Over-the-counter Codeine, i.e. Tylenol #1 & 3's
☐ Benzodiazepine, i.e. Ativan, Valium	☐ Heroin/opium	☐ Prescription Opioids, i.e. Morphine
☐ Cocaine	☐ Marijuana	

Have you ever experienced any of the following: (please check all that apply)

☐ Hangovers ☐ Blackouts ☐ Vomiting ☐ Seizures ☐ Shakes ☐ Hallucinations ☐ Paranoia

Injection Drug Use: ☐ Yes ☐ No

Previous Treatment Attempt(s) ☐ No ☐ Yes (Please complete below)

Name of Facility	Date	Completed
How long were you clean/sober after treatment?		
What do you identify as the reasons for returning to drinking/drug use:		

MENTAL ASPECT OF SELF

Mental Health History

Do any of the following apply to you? (Please check all that apply)

☐ Tension, anxiety, nervousness ☐ Eating disorder(bingeing, starving) ☐ Sexual abuse/assault ☐ Physical/emotional/mental abuse	☐ Low self-esteem ☐ Grief issues ☐ Depression ☐ Fears, phobias	☐ Sexuality concerns ☐ Anger/aggression problems ☐ Difficulty expressing emotions ☐ sleeping disorders

Have you ever had one of the following? (please check all that apply)	YES	NO
Suicidal thoughts		
Self-harm behavior		
Attempted Suicide		

Please describe in detail: (i.e. what you did, you do, when, how current plan, etc.)	
Use this space to give more detail, if required	
Have you ever been hospitalized for a mental health issue? ☐ No ☐ Yes	
When	Facility
Have you ever had counselling for mental health issues? ☐ No ☐ Yes	
Name	Agency
Date	How long
Please indicate what issues were addressed	
Would you be willing to sign a release of information to access reports from the above agency(s)? ☐ No ☐ Yes	
Are counselling/therapy ongoing? ☐ No ☐ Yes	

EMOTIONAL ASPECT OF SELF

Family Background Information

Family type (please check)

☐ Living alone ☐ Single parent ☐ Spouse and children ☐ With spouse ☐ With parents

Your Family of Origin

Parent Names	Living	Deceased
Mother		
Father		
Step-mother		
Step-Father		

Brothers' Name	Biological	Step/half	Living	Deceased

Sisters' Name	Biological	Step/half	Living	Deceased

Children' Name & DOB	Biological	Step/half	Living	Deceased

Family History

Who raised you? ☐ Parents/Grandparent(s) ☐ Extended Family ☐ Foster parent(s) ☐ Adoptive parent(s)

Were you raised: ☐ On reserve ☐ Off Reserve ☐ Combination (both on/off reserve)

	YES	NO
As a child did you witness parental drinking?		
As a child did you witness any violence between parents?		
Were you exposed to any other kind of violence?		
Did you experience any inappropriate sexual behaviour by adults? Other children? Community members?		
Did you experience a suicide death of family member /close friend?		
Have you been sexually abused or sexually assaulted?		
Did you experience divorce or separation of parents?		
Were you ever emotionally abused?		
Did you, your parents or grandparents attend Residential School?		
What Residential school did you or your family member attend?		
Please briefly describe what this experience was like for you or your family member?		

GENOGRAM

SPIRITUAL ASPECT OF SELF

Please briefly describe your belief system.
What traditional practices do you participate in?

Strengths and Resources

What gives you hope?
What do you see as your personal strength?

Goals for Treatment

What are your goals for treatment?
What do you see as important areas to work on in treatment in order to achieve your goals?

What group treatment/therapy have you experienced?
What is your availability for treatment?
What do you see as the biggest barrier or potential barrier for attending treatment?

PRE-TREATMENT SERVICES

	YES	NO
Withdrawal management services (detoxification)		
Stabilization prior to treatment-supportive service housing, individual counselling, attend meetings		
Medical services-medication management, physical assessment, medical procedures		
Psychiatric services-psychological or psychiatric assessment, medication stabilization		

AFTER-CARE PROGRAM INTAKE QUESTIONAIRE

(Complete if only apply for the aftercare program)

	YES	NO
Have you graduated from a structured alcohol or drug abuse treatment program?		
Name of alcohol or drug abuse treatment program / Date of treatment graduation		
Are you currently alcohol and drug free?		
How long have you been alcohol and drug free?		
If you have mental illness, is the illness treated and stabilized? Please explain.		
Are you a resident of the Rainy River District?		
Are you willing to sign an Aftercare Service Contract?		
Are you willing to sign any required release of information forms?		
What are your current concerns regarding your recovery?		
What are your current services needs regarding your recovery?		
What are some risk factors regarding alcohol and drug relapse?		

Client Signature	Date
Intake Counsellor Signature	Date